1. the length of stay exceeds 20 cumulative acute days (not including days in a distinct part psychiatric unit);
2. the hospital has fulfilled its discharge planning duties as required by 130 CMR (Division of Medical Assistance regulations);
3. the patient continues to need acute level care and is therefore not on administrative day status on any day for which outlier payment is claimed;
4. the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed.

(b) The outlier *per diem* payment amount is equal to 55% of the statewide standard payment amount per day multiplied by the hospital's wage area index and Medicaid casemix index, plus a *per diem* payment for the hospital's pass-through costs, direct medical education, and reasonable capital costs. The statewide standard payment amount per day is equal to the statewide standard payment amount per discharge divided by the statewide average FY95 all payer length of stay. The pass-through, direct medical education and reasonable capital cost *per diem* payments are equal to the per discharge amount for each of the components divided by the hospital's Medicaid length of stay.

114.1 CMR 36.07

(c) Pediatric Outlier Payment. In accordance with 42 U.S.C. 1396a(s), an annual pediatric outlier adjustment is made to acute care hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for children greater than one year of age and less than six years of age. Only hospitals that meet the Basic Federally-Mandated Disproportionate Share eligibility per 114.1 CMR 36.07(9)(b) are eligible for the pediatric outlier payment. The Pediatric Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.
2. Eligibility is determined by the Division as follows:
   a. Exceptionally long lengths of stay: First, calculate a statewide weighted average Medicaid inpatient length of stay. This is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. Second, calculate the statewide weighted standard deviation for Medicaid inpatient length of stayThird, multiply the statewide weighted standard deviation for Medicaid inpatient length of stay by two and add that amount to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.
   b. Exceptionally high cost. Exceptionally high cost is calculated for hospitals providing services to children greater than one year of age and less than six years of age by the Division as follows:
      1. First, calculate the average cost per Medicaid inpatient discharge for each hospital.
      2. Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital.
      3. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.
   c. Eligibility for an Outlier Adjustment in the Payment Amount. For hospitals providing services to children greater than one year of age and under six years of age, the Division calculates the following:
      1. the average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.07(3)(c)2.a., then the hospital is eligible for an outlier adjustment in the payment amount.
      2. the cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this hospital-specific Medicaid

inpatient cost equals or exceeds the threshold defined in 114.1 CMR 36.07(3)(c)2.b., then the hospital is eligible for an outlier adjustment in the payment amount.

3. Payment to Hospitals. Hospitals qualifying for an outlier adjustment in the payment amount pursuant to 114.1 CMR 36.07, receive 1/2% of the total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(9)(b)5. The total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(9)(b)(5) are reduced by the payment amount under 114.1 CMR 36.07.

114.1 CMR 36.07 (d) Infant Outlier Payment In accordance with 42 U.S.C. 1396a(s), an annual infant outlier payment adjustment is made to hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for infants under one year of age. The Infant Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.
2. Eligibility is determined by the Division as follows:
   a. Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated.
   The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.
   b. Exceptionally High Cost is calculated for hospitals providing services to infants under one year of age by the Division as follows:
      1. First, the average cost per Medicaid inpatient case for each hospital is calculated;
      2. Second, the standard deviation for the cost per Medicaid inpatient case for each hospital is calculated;
      3. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two, and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.
   c. Eligibility for an Outlier Adjustment in the Payment Amount. For each hospital providing services to infants under one year of age, the Division determines first, the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.07(3)(d)2.a., then the hospital is eligible for an outlier adjustment in the payment amount.
   Second, the cost per inpatient Medicaid case involving infants under one year of age is calculated. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in 114.1 CMR 36.07(3)(d)2.b. above, then the hospital is eligible for an outlier adjustment in the payment amount.
   d. Payment to Hospitals. Annually, each hospital that qualifies for an outlier adjustment receives an equal portion of $50,000. For example, if two hospitals qualify for an outlier adjustment, each receives $25,000.

(4) Rates of payments for transfer patients. 114.1 CMR 36.07(4) applies to payments for patients transferred from one acute hospital to another and for patients transferred between units within a hospital..

(a) Transfers between hospitals.

TN 97-14
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 6: 114.1 CMR 36.07(9)

OFFICIAL

bill for the hospital-based physician payment, as the fee represents payment in full for all services associated with the Norplant System of Contraception.

(s) Audiology Dispensing Hospitals are reimbursed for the dispensing of hearing aids by a hospital-based audiologist according to the Audiologist regulations at 130 CMR 426.00 *et seq*, and at the lower of the most current of the Division of Health Care Finance and Policy fees as established in 114.3 CMR 23.00, or the hospital's usual and customary charge.

(t) Therapy Services Hospitals are reimbursed for physical, occupational, or speech/language therapy services according to both the Therapist Regulations in 130 CMR 432.000 and the cost to charge ratio or the hospital's usual and customary charges, whichever is lower. Therapy services provided the day before, the day of, and/or the day after a significant procedure are reimbursed according to the APG significant procedure group, as specified in 114.1 CMR 36.07(7)(d)1.

(8) Rates of Payment for Emergency Services at Non-Contracting Hospitals 114.1 CMR 36.07(8) establishes rates of payment to acute care hospitals who have not signed a contract with the Division of Medical Assistance. Rates of payment for all emergency services and continuing emergency care provided in an acute hospital to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395 (dd), are as follows, with the exception of any outpatient services provided the day before, the day of, and/or the day after a significant procedure, which are reimbursed according to the APG significant procedure group, as specified in 114.1 CMR 36.07(7)(d)1.

(a) Rates of payment for emergency services provided in clinics, emergency rooms or trauma centers are established according to the methodology set forth in 114.1 CMR 36.07(7)(a), (7)(b) and (7)(c).

(b) Rates of payment for emergency significant procedure and radiology services are established according to the methodology set forth in 114.1 CMR 36.07(7)(d).

(c) Rates of payment for emergency laboratory and ancillary services are established according to the methodology set forth in 114.1 CMR 36.07(7)(e) and (7)(f).

(d) Rates of payment for emergency services provided by ambulance services are established according to the methodology set forth in 114.1 CMR 36.07(7)(g).

(e) Rates of payment for emergency dialysis services are established according to the methodology set forth in 114.1 CMR 36.07(7)(h).

(f) Rates of payment for emergency psychiatric day treatment are established according to the methodology set forth in 114.1 CMR 36.07(7)(i).

(g) Rates of payment for emergency dental services are established according to the methodology set forth in 114.1 CMR 36.07(7)(j).

(h) Payment for emergency inpatient admissions is made using the transfer *per diem* rate of payment, established according to the methodology set forth in 114.1 CMR 36.07(4), up to the hospital-specific standard payment amount per discharge, established according to the methodology set forth in 114.1 CMR 36.07(2). If the data sources specified in 114.1 CMR 36.07 are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.07, the Division will select such substitute data sources that the Division deems appropriate in determining hospitals' rates. Hospitals must notify the Division of Medical Assistance within 24 hours of admitting a Medicaid beneficiary in order to be eligible for payment pursuant to 114.1 CMR 36.07(8).

(i) Rates of payment for emergency recovery and observation bed services are established according to the methodology set forth in 114.1 CMR 36.07(7)(q).

(j) Rates of payment for emergency services provided by a hospital-based physician are established according to the methodology set forth in 114.1 CMR 36.07(7)(p).

(k) Rates of payment for emergency services related to the Norplant System are established according to the methodology set forth in 114.1 CMR 36.07(7)(r).

14.1 CMR 36.07

(9) Classifications of Disproportionate Share Hospitals (DSHs) and Payment Adjustments The Medicaid program assists hospitals that carry a disproportionate financial burden of caring for the uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid makes an additional payment adjustment above the rates established under 114.1 CMR 36.07(9) to hospitals which qualify for such an adjustment under any one or more of the following classifications. Only hospitals that have an executed contract with the Division of Medical Assistance are eligible for disproportionate share payments.

Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments are described in 114.1 CMR 36.07(9). Medicaid payment adjustments for disproportionate share hospitals are a source of funding for allowable uncompensated care costs.

When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment is determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (114.1 CMR 36.07 (9)). If a hospital's Medicaid contract is terminated, any adjustment is prorated for the portion of the year during which it had a contract, the remaining funds it would have received are apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals are informed if an adjustment amount changes due to reapportionment among the qualified group and told how overpayments or underpayments by the Division of Medical Assistance are handled at that time.

To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.07(9), a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a disproportionate share payment adjustment under 114.1 CMR 36.07(9) a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%.

Effective October 1, 1995 the total amount of DSH payment adjustments awarded to a particular hospital under 114.1 CMR 36.07(9) cannot exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and from uninsured patients, and as provided at 42 U.S.C. § 1396r-4(g).

(a) High Public Payer Hospitals: Disproportionate Share Status under M.G.L. 118G.

1. Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.06 are eligible for this adjustment.
2. Calculation of Adjustment.
   a. The Division of Medical Assistance allocates $11.7 million for this payment adjustment.
   b. The Division then calculates for each eligible hospital the ratio of itst allowable free care charges, as defined in M.G.L. c. 118G, to total charges. Free care charge data will be obtained from the hospital's prior year filing of the Division's uncompensated care reporting form.
   c. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 36.07(9)(a)2.b.
   d. The Division then determines the 75th percentile of the ratios determined in 36.07(9)(a)2.b.
   e. Hospitals who meet or exceed the 75th percentile qualify for a High Public Payer Hospitals Adjustment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.1 CMR 36.05 to determine allowable free care costs.
   f. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(9)(a)2.e for all hospitals that qualify for a High Public Payer adjustment.
   g. Each eligible hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.07(9)(a)2.a. multiplied by the amount determined in 114.1 CMR 36.07(9)(a)2.e. and divided by the amount determined in 114.1 CMR 36.07(9)(a)2.f.

(b) Basic Federally - Mandated Disproportionate Share Adjustment

1. The Division determines a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

a. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form..

b. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

2. The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division determines such threshold as follows:

a. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

b. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

c. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

d. The Division then calculates each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(9)(b)2.c., then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

3. The Division then calculates each hospital's low-income utilization rate as follows:

a. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

b. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

c. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(9)(b)3.a. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(9)(b)(3)b. If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

4. Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement is calculated as follows:

a. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.07(9)(b), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(9)(b)2.d. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(9)(b)2.c. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

b. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

c. The Division then determines, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(9)(b)4.a. and 114.1 CMR 36.07(9)(b)4.b.

d. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(9)(b)5. by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.07(9)(b)4.c.

e. The Division then multiplies the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.07(9)(b)4.a. and b. The product of such multiplication isthe payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

5. The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement is $200,000 per year. These amounts are paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(9)(b)4.e.

(c) Disproportionate Share Adjustment for Safety Net Providers. The Division determines a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.07(9)(c)1. through 3..

1. Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC-9x report and total charges from the DHCFP-403. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

2. Eligibility of Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is a payment for hospitals which meet the following criteria:

a. is a public hospital or a public service hospital as defined in 114.1 CMR 36.07(2)(j)3.;

b. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by the Division of Health Care Finance and Policy which is at least 15% of its total charges;

c. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;

d. has completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the disproportionate share adjustment for safety net providers;

e. is the subject of an appropriation requiring an intergovernmental funds transfer;

f. the public entity obligated to make an intergovernmental funds transfer does in fact meet its obligation in accordance with the agreement referenced at 114.1 CMR 36.07(9)(c)2.d. above.

3. Payment to Hospitals under the Adjustment for Safety Net Providers. The Division calculates an adjustment for hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.07(9)(c)2. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers is not in effect for any rate year in which Federal Financial Participation (FFP) under Title XIX is unavailable for this payment. The amount payable is also subject to the amount of FFP which continues to be available for this payment.

4. If a public entity has not met its obligation to make an intergovernmental funds transfer, the Division of Medical Assistance shall have the right to recoup any safety net disproportionate share payment amount which is conditioned on the receipt by the Commonwealth of said intergovernmental funds transfer.

(d) Uncompensated Care Disproportionate Share Adjustment Hospitals eligible for this adjustment are those that report "free care costs," as defined by 114.6 CMR 7.00 and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 7.00. These payments are made to eligible hospitals in accordance with Division's regulations and the ISA between the Division of Medical Assistance and the Division of Health Care Finance and Policy. Eligible hospitals receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

(e) Public Health Substance Abuse Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000, as limited in DPH's Interagency Service Agreement (ISA) with the Division of Medical Assistance (DMA). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 and DPH's ISA with DMA.

(10) Data Sources The following data sources are used in the development of the Medicaid rates. The FY95 RSC-403 cost report is used to develop the pass through amounts (with the exception of capital) and the base cost per discharge. Capital pass throughs and the wage area index are calculated from the HCFA-2552 Medicare Cost report. All payor casemix indices are calculated using the New York weights, version 12 New York Grouper. Medicaid casemix indices are calculated using the paid claims database for the time frame specified in 114.1 CMR 36.07

(11) Upper Limit Review and Federal Approval. Medicaid rates of payment calculated under the provisions of 114.1 CMR 36.07(12) conform to the upper limit requirement imposed by Title XIX of the Social Security Act. That is, the federal government requires that states certify that inpatient hospital payments in the aggregate do not exceed the amount of payments that would result if payments were based on the Medicare principles (TEFRA). Rates of payment established pursuant 114.1 CMR 36.07 are adjusted if it is determined that aggregate payments exceed this limit or if adjustments are required by the Health Care Financing Administration (HCFA).

(12) Hospital Mergers and New Hospitals.

(a) Hospital Mergers: For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership, or operation of the hospital during the fiscal year, the Division may have to make adjustments to the hospitals' rates. The Division will determine the best available data source(s) for these adjustments.

(b) New Hospitals: The rates of reimbursement for new hospitals shall be determined in accordance with the provisions of 114.1 CMR 36.07 to the extent the Division deems possible. If the data sources specified in 114.1 CMR 36.07 are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.07, the Division will select such substitute data sources that the Division deems appropriate in determining hospitals' rates.

(13) Reporting Compliance. All hospitals are required to submit to the Division and the Division of Medical Assistance documents needed for the calculation of Medicaid rates of payment. These documents include, but are not limited to, the reports required pursuant to 114.1 CMR 36.09 and the HCFA-2552 cost report. If the hospital does not submit this information in a timely fashion, the hospital's SPAD payment rate may be reduced by 5% on the day following the date the submission is due. This reduction accrues in a cumulative manner of 5% for each month of non-compliance. For example, the downward adjustment to the hospital's

160.402: Orientation

The licensee shall provide a new patient with an orientation which will familiarize him/her with the rules, procedures, activities, policies, and philosophy of the program, including program requirements for participation and disciplinary, termination, and grievance procedures. Written evidence of this orientation shall appear in the clinical record.

160.403: Evaluation and Diagnosis

(A) Immediately upon admission a physical assessment of the patient shall be made by a qualified health professional. Within 24 hours of admission, a complete physical examination shall be completed. If the examination is conducted by a qualified health professional and not a physician, the results of the examination and any recommendations made as a result of the examination, shall be reviewed by the nursing supervisor prior to implementation. For multiple admissions, the time, frequency and interval of a complete physical examination shall be subject to physician discretion.

(B) Upon admission, or as soon as the patients physical condition permits, a thorough personal history shall be obtained.

(C) Both the medical and psychosocial evaluation and medical include an assessment of the patient's psychological, social, health, economic, educational/vocational status; related legal problems; involvement with alcohol and drugs and any other associated conditions. The evaluation must be completed before a comprehensive service plan is developed for the patient.

(D) When the initial evaluations indicate a need for further assessment, the program shall conduct or make referral arrangements for necessary testing, physical examination and/or consultation by qualified professionals.

(E) If the psychosocial evaluation is performed by a Clinician III, it must be reviewed and approved, in writing, by his/her supervisor.

160.404: Service Plan

(A) Each patient shall have a written initial individualized service plan developed based on information gathered during the admission and evaluation sessions. Service plans developed or revised by a Clinician III shall be reviewed and signed by his/her supervisor.

(B) The service plan and any subsequent updates shall include at least the following information:

(1) A statement of the patient's problem in relation to his/her misuse of alcohol and drugs,
(2) Service goals with timelines,
(3) Evidence of patient involvement in formulation of the service plan,
(4) Aftercare goals,
(5) The date the plan was developed and/or revised,
(6) The signatures of staff involved in its formulation or review.

(C) Individual service plans shall be reviewed with the patient and amended, as necessary. A summary of such periodic reviews shall become a part of the patient record.

160.405: Medical Services

(A) Where appropriate, the licensee shall operate in accordance with:

(1) M.G.L. c. 94C
(2) The rules and regulations of the Federal Food and Drug Administration (FDA), and
(3) The rules and regulations of the Drug Enforcement Administration (DEA).

160.405: continued

(B) The Medical Director shall be responsible for administering all medical services performed by the service, be licensed to practice medicine in the Commonwealth of Massachusetts, and where possible have experience in working with substance abusing persons. In addition, the Medical Director, or any other authorized staff physician shall be responsible for the following minimum requirements:

(1) Ensuring that a medical evaluation, including a medical history has been taken,
(2) Ensuring that appropriate laboratory studies have been performed, and,
(3) Signing or countersigning all medical orders.

(C) Physical Examinations. The physical examination shall, at a minimum, include an investigation of the possibility of infectious diseases, pulmonary, liver, and cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems. Prior to prescribing, dispensing or administering any drug, the licensee shall assure itself that the drug will not interfere with any other drug(s) the patient has reported taking.

(D) Laboratory Tests

(1) Each patient shall receive a tuberculin skin test at least every 12 months, when the tuberculin skin test is positive, a chest x-ray,

(2) When appropriate, the licensee shall also perform the following laboratory tests within 48 hours after admission:

(a) Urine screening for drug determination,
(b) Complete blood count and differential,
(c) Serological test for syphilis,
(d) Routine and microscopic urinalysis,
(e) Urine for Glucose and Protein (GL/PR),
(f) Liver function profile, *e.g.* SGOT, SGPT, *etc.*,
(g) An EKG,
(h) Australian Antigen HB AG testing (HAA testing), and,
(i) A pregnancy test.

(E) Where the drug being dispensed is a narcotic-like substance or a narcotic antagonist, two or more proofs of narcotic or other drug dependence must be present. Such proofs may consist of:

(1) Two or more positive urine tests for opiate or morphine-like drugs,
(2) The presence of old and fresh needle marks,
(3) Early physical signs of withdrawal,
(4) Documented evidence from the medical and personal history,
(5) Physical examination, and,
(6) Laboratory tests.

(F) Pharmacological services shall be provided as needed by staff physicians.

(G) The licensee shall document in the patient record any situation that requires a patient to stay in treatment longer than the prescribed service plan indicated. The record shall be updated every seven days.

160.406: Counseling Services

(A) Services offered shall include:

(1) Individual counseling,
(2) Group counseling,
(3) Educational groups,
(4) Self-help groups such as Alcoholics Anonymous, Al-Anon and Narcotics Anonymous and,
(5) Structured social rehabilitative activities.

160.406: continued

(B) The licensee shall provide each patient who has been medically cleared with a minimum of ten hours of direct service per week, including:

(1) At a minimum, one hour of individual counseling,
(2) Four hours of group counseling, and
(3) Five hours of education, self-help or social rehabilitation.

(C) Patient assignment to staff should be based on a patient's needs and staff expertise.

(D) The licensee shall provide case management which shall at a minimum include:

(1) Crisis referrals,
(2) Health care referrals,
(3) Continuum of care referrals,
(4) Aftercare referral.

(E) The licensee shall provide or make referral arrangements for the provision of additional services as needed.

(F) The licensee shall provide AIDS education to all patients admitted to the service. AIDS education shall be provided by a qualified professional and conform to policies set forth by the Department. Evidence of this AIDS education shall appear in the patient record.

(G) Where the licensee utilizes an outside agency(ies) for the provision of direct patient services, formal written agreements shall be maintained and reaffirmed every two years.

160.407: Termination

(A) The licensee shall establish and maintain written procedures detailing the termination process and shall incorporate them into the policies as described in 105 CMR 160.402. These procedures shall include:

(1) Written criteria for termination, defining:
  (a) Successful completion of the program,
  (b) Voluntary termination prior to program completion,
  (c) Involuntary termination,
  (d) Medical discharge, and,
  (e) Transfers and referral.

(2) Rules of required conduct and procedures for both emergency and non-emergency involuntary terminations in accordance with the following requirements:

  (a) In an emergency situation, where the patient's continuance in the program presents an immediate and substantial threat of physical harm to other patients or program personnel or property or where the continued treatment of a patient presents a serious medical risk to the patient as determined by the medical director or the nurse-in-charge, the licensee may suspend a patient immediately and without provision for further detoxification. The patient shall be afforded an appeal as described in the program policies.

  (b) In a non-emergency situation, wherein the patient's continuance does not present the immediate and substantial threat or serious medical risk described in 105 CMR 160.407(A)(2)(a), the licensee may not terminate the patient without first affording him/her the following procedural rights:

    1. A statement of the reasons for the proposed termination and the particulars of the infraction, including the date, time and place,
    2. Notification that the patient has the right to request an appeal, according to program policies,
    3. The date, time and place of the appeal if the patient elects to appeal, and,
    4. A copy of the licencee's grievance procedures.

(B) Upon termination a written dischagre summary shall be included in the patient record.

160.407: continued

(C) The discharge summary shall contain, but need not be limited to:
(1) Description of the treatment episode,
(2) Sobriety status and a description of current drug and alcohol use,
(3) Reason for termination,
(4) A summary of any disciplinary action taken, including:
(a) The reasons therefor, and,
(b) Patient notification of appeal, and,
(5) Referrals

160.408: Aftercare

(A) The licensee shall make referral arrangements for the provision of post discharge counseling and other supportive service.

(B) The licensee shall maintain and make available to patients as needed, a file of available community service which shall include a description of the services, its address and phone number and the name of a contact person.

(C) Aftercare service referrals shall be documented in the patient record.

REGULATORY AUTHORITY

105 CMR 160.000: M.G.L. c. 111B, § 6; c. 111E, § 7.

114.3 CMR 46.00 RATES FOR CERTAIN SUBSTANCE ABUSE PROGRAMS

Section

46.01: General Provisions

(1) Scope. 114.3 CMR 46.00 governs rates of payment to be used by all governmental units making payment to eligible providers for Acute Treatment Services, Recovery Home, Residential Drug-Free Program, Substance Abuse Outpatient Counseling, Outpatient Methadone Medical Service, Driver Alcohol Education Services, Enhanced Detoxification Day Treatment, and Case Management to publicly assisted clients.

(2) Disclaimer of Authorization of Services. 114.3 CMR 46.00 is neither authorization for nor approval of the substantive services for which rates are determined pursuant to 114.3 CMR 46.00. Governmental units which purchase services from eligible providers are responsible for the definition, authorization, and approval of services extended to publicly assisted clients.

(3) Effective Date. 114.3 CMR 46.00 shall be effective from July 1, 1996.

(4) Authority. 114.3 CMR 46.00 is adopted pursuant to M.G.L. c. 118G.

46.02: Definitions

Meaning of Terms. As used in 114.3 CMR 46.00 unless the context requires otherwise, terms shall have the meanings ascribed in 114.3 CMR 46.02.

Acute Treatment Services (Inpatient) Level III A, B, and C. These medically monitored acute intervention and stabilization services provide supervised detoxification to individuals in acute withdrawal from alcohol or other drugs and /or address the biopsychosocial problems associated with alcoholism and other drug addictions requiring a 24 hour supervised inpatient stay.

(a) Level IIIA services provide acute detoxification and related treatment to individuals assessed as being at risk of severe withdrawal syndrome, utilizing detoxification protocols, standing orders, and physician consultations. These services are governed by the Massachusetts Department of Public Health Regulation 105 CMR 160.000. A facility licensed under 105 CMR 160.000 may provide Levels III A, B and C.

(b) Level IIIB services provide continuing medical assessment and intensive counseling and case management for clients who are not intoxicated or have been safely withdrawn from alcohol or other drugs and who require a 24 hour supervised inpatient stay to address the acute emotional, behavioral and/or biomedical distress resulting from an individual's use of alcohol or other drugs. These services are governed by the Massachusetts Department of Public Health Regulation 105 CMR 161.000. A facility licensed under 105 CMR 161.000 may provide Levels III B and C.

(c) Level IIIC services provide inpatient transitional services, including continuing medical assessment, counseling and aftercare planning, for clients who have completed a Level IIIA or IIIB service and who are expected to be transferred to a longer term residential rehabilitation program. These services are governed by the Massachusetts Department of Public Health Regulation 105 CMR 161.000. A facility licensed under 105 CMR 161.000 may provide Level C.